The Effects of COVID-19 on People Experiencing Mental Ill-health, Substance Use Disorder and Homelessness or Housing Insecurity in the Dublin Region: A Qualitative Exploration

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Kathyan Kelly
Independent Research Consultant

MQI
Merchants Quay Ireland

ACCES

> ‘I suffered delusions ... it got to a head one Friday night.
> This was in the middle of lockdown.
> I wanted to commit suicide ... I was going to go to [another country]
> and commit suicide and for some reason I came back to get
> my laptop and there was some texts on my phone...
> from my psychologist.
> And it made me question... my assumption that
> [his psychologist no longer wanted to treat him].
> So, I re-engaged and I kind of told them what was going on
> and they felt it was best I go into hospital for a little while.’

(David, aged 45-49 years) who has a severe mental health illness, describes the change in his decision to take his own life following Outreach intervention during the first national lockdown in Ireland.

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GLOSSARY OF TERMS USED

AOT Assertive Outreach Team
BZD Benzodiazepine
CAMHS Child and Adolescent Mental Health Services
CMHTs Community Mental Health Teams
DPHLG Department of Planning, Housing and Local Government
DRHE Dublin Regional Homeless Executive
EMCDDA European Monitoring Centre for Drugs and Drug Addiction
ETHOS European Typology on Homelessness and Housing Exclusion
FEANSTA European Federation of National Organisations Working with the Homeless
GAD Generalised Anxiety Disorder
GDPR General Data Protection Regulation
GP General Practitioner
HRB Health Research Board
HSE Health Service Executive
HSE ACCES Health Service Executive Assertive Community Care Evaluation Service
HIV Human Immunodeficiency Virus
ICON Inner City Organisations Network
IT Information Technology
MQI Merchants Quay Ireland
MDMA Methylenedioxymethamphetamine
MMT Methadone Maintenance Treatment
NACD National Advisory Committee on Drugs
OST Opioid Substitution Treatment
PIL Participant Information Leaflet
QSR Qualitative Research Software
RCSI Royal College of Surgeons in Ireland
SAC Scientific Advisory Committee
WHO World Health Organisation

1.0 INTRODUCTION

This qualitative research study aims to explore the psychological effects of changes in service delivery than have ensued as a result of COVID-19 for people in Dublin experiencing mental illness, substance use and/or homelessness or any combination of these.

Two services are engaged in the care of and support for this population (Merchants Quay Ireland (MQI) and the HSE ACCES programme (see pp8) have experienced considerable change which has required high levels of flexible adaptation to continue with service provision.

The research focusses on the lives of ten participants – five linked in to MQI and five linked in to HSE ACCES – who have experience of a mental health illness, substance use issue and/or homelessness, or any combination of these both before and after the onset of the COVID-19 pandemic.

The first section gives an overview of Irish policy on those issues, as well as the Irish Government's response to COVID-19 for those with mental health and substance use issues as well as homelessness.

The second section documents the methodological approach to the study while the third section provides a brief sociodemographic profile of the participants as well as profile of their mental health, substance use and housing.

The fourth section presents the findings of the study – an analysis of the participants lived experience of COVID-19 and the meanings attached by them to that experience in terms of their mental health and well-being.

The fifth section places those experiences in the context of relevant research, allowing for the sixth and final, section which provides a conclusion and recommendations based on the input from the study's participants.

2.0 LITERATURE REVIEW

Introduction

This section takes a brief look at Irish policy in relation to mental health, substance misuse and housing, as well as the prevalence and complexity of all three. It then provides an overview of how the COVID-19 pandemic has impacted health services and examines Irish Government response to mental health, substance use and housing. It also provides an exploration of the social issues around COVID-19 in terms of mental health, housing and substance use. This section concludes by examining the possibility of return to services and how that will look for planning for both the immediate and long-term response to COVID-19.

2.1 An Overview of Irish Policy on Mental Health, Substance Misuse and Homelessness Prior to COVID-19

Mental Health Policy

The de-institutionalisation of Irish psychiatric hospitals took place over a period of time from the 1960s to 2013. Having once had the highest hospitalisation rate of any comparable country, the provision of acute psychiatric care in the public sector is now provided within general hospital units (Walsh 2015).

Ireland did not have a national mental health policy until 2006, with the publication of ‘A Vision for Change.’ This strategy envisaged that the care of people with mental health issues would be rooted in the community, with the establishment of a number of Community Mental Health Teams (CMHTs) for adults around the country which could provide outpatient support. Children and young people were also to be provided with mental health care with the establishment of CAMHS (Child and Adolescent Mental Health Services) (HSE 2006).

A subsequent review of that policy in 2015 found that many of the targets outlined in that strategy had not been reached, noting that there was evidence of inequity related to variations in service models, delivery and choice. That review noted that restructuring of the HSE at the time of expected delivery meant that designated funds were lost to other parts of the health service and culminated in the cessation of funding for a period of time. Added to this was the problem created by an economic downtown and the loss of staff, all which led to a situation where waiting lists increased at a time when mental health needs were increasing, leading to a focus on crisis management for staff (Mental Health Reform 2015). This was of particular concern to the lack of mental health services for young people, with consistent evidence finding that that mental ill-health often emerges during adolescence and early adulthood.(Cannon et al 2013).

Ireland generally has a low national spend on mental health services – at 6% of the total health budget (compared with 12% in the UK) and the third lowest number of psychiatric beds in Europe and mental health services are underfunded across the board (O'Connor et al 2020).

A new policy 'Sharing the Vision' has recently been launched which aims to restructure and fund mental health services in Ireland based on review of past policy. The key issues to be addressed include prioritising mental health as a major societal issue, as well as key deliverables in terms of prevention and the expansion of services to address a spectrum of need, taking a life cycle approach and noting the need for a collaborative approach on the issue of dual diagnosis (Department of Health 2020).

Mental Health and Dual Diagnosis

Long-term substance misuse (both alcohol and drugs) is often accompanied by poor mental health (depression and anxiety), with a number of studies indicating that clients presenting for substance misuse also experience mental ill-health, and high levels of mental ill health in those using cocaine and alcohol (Iro and O'Connor 2009; Lyne et al 2010). For people with more enduring/severe mental disorders (schizophrenia and associated disorders) more than two-thirds had been using alcohol and cannabis over prolonged period of time (Kamali et al 2000).

Dual diagnosis is a term generally used to describe a person presenting with both addiction and mental health issues. As a result of the national mental health policy outlined in 'A Vision for Change', the responsibility for those with severe co-morbid mental illness and substance abuse was placed outside of the mental health system and placed within the remit of Community Health Care Teams (CHCTs) (Department of Health 2006; Mental Health Reform 2015).

However, a combination of recession and re-organisation of the HSE, as discussed earlier, compounded the situation and left people with dual diagnosis in a vacuum, unable to access community health, mental health or addiction services and often cycling between the three continuously and receiving no treatment at all. A study by Proudfoot et al (2019) concluded that that there *was 'almost complete lack of co-ordinated Dual Diagnosis service provision with separate Government departments, policy and service provision and orientation'* (Proudfoot, MacGabhann and Phelan 2019 pp10).

The newly launched mental health policy, Sharing the Vision, recognises that earlier policies excluded people who co-present with substance use issues, leaving them unable to access mental health services. The new policy notes that those with co-existing mental health difficulties should also be able to access mental health services. and it should be immaterial whether the mental health issue or the substance use issue is the primary presentation, signalling a move towards a more holistic approach (Department of Health 2020).

Substance Use Policy

The Irish Governmental Act (Misuse of Drugs Act 1977) was not acted upon until the advent of what became known as the first ‘heroin epidemic’ in Dublin in the 1980s. It was at this time that the problems (especially the high level of deaths) associated with heroin use led to the Irish Government response with a number of initiatives based on an abstinence model (i.e. focussing on the aim of people becoming drug-free). The model was predominantly a medical model, with a strong emphasis on the illegality of substance use, and community services were absent (Butler 2017).

With the advent of a newly discovered virus (HIV), which was prevalent in injecting heroin users (termed the ‘second heroin epidemic’ in the 1990s), the focus shifted towards a harm reduction approach (O’Gorman 1998). This led to the introduction of opioid management (Opioid Substitution Treatment – OST) through the use of Methadone Maintenance Treatment (MMT). Satellite MMT Clinics were set up around Dublin City (by what was then the EHB) to provide specific on-site dosages of methadone. While the focus was on reducing the health-related harms associated with (injecting) heroin use, a further aim was to reduce the levels of criminal activity associated with heroin use. This was coupled with increased policing around supply and organised crime, both of which had the effect of viewing the issue as primarily within the remit of criminal justice services (Butler 2017).

However, a large number of drug-related deaths in Dublin’s North East Inner City, coupled with strong protests by community members at the absence of real support, led to Government acting at a local level with policy endorsement of this approach much further down the line (EMCDDA 2016).

Problem alcohol use is recognised as a considerable public health issue in Ireland, with figures indicating that 1.35m people in Ireland can be classified as ‘harmful drinkers’ and a further 150,000 as dependent drinkers (HRB 2016). Alcohol misuse is linked to morbidity, health issues, poor mental health and suicide (HRB 2014). A major driver of alcohol-related harm in Ireland is binge drinking (drinking until drunk) and three-quarters of all harmful drinking in Ireland is related to binge drinking (HRB 2019).

Initial drug policy in Ireland did not include alcohol as a substance misuse issue initially (Department of Health 2001) and it was not until 2009 that a policy was developed which focused on both alcohol and drugs. More recent Governmental response ’Reducing Harm. Supporting Recovery’ recognises the health and social problems associated with drug and alcohol misuse This latest strategy focusses on a health-led response to substance misuse (drugs and alcohol) and responsibility for the policy lies within the remit of the Health Service Executive and its Social Inclusion division (Department of Health 2017). The policy recognises other findings that people caught in a cycle of substance misuse need a comprehensive range of services in order to enable them to live meaningful lives (Mayock, Butler and Hoey 2018).

’Reducing Harm, Supporting Recovery’ is an eight-year strategy which centres on harm reduction and recovery support in the field of addiction for both alcohol and drugs. In proposing a ‘continuum of care model’ it aims to provide access to the supports needed for individuals to attain personal recovery goals where the intervention is less on drug treatment and more on social care at its initial level (family, housing, education, criminal justice and healthcare supports). It also focusses on addiction interventions (community based, outreach) and then on to specialised care within institutional settings (hospital, prison etc). The strategy acknowledges the need to develop an ‘integrated care pathway’ which is the shared responsibility of a number of key stakeholders at national, local and personal levels (Department of Health 2017).

Housing Policy

Housing in Ireland is covered by a number of key legislative Acts and homelessness is defined as where a person experiences a lack of reasonable accommodation, those living in a shelter or where a person is unable to provide accommodation from their own resources (Housing Act 1988). This narrow definition is at odds with the more inclusive ETHOS definition developed by FEANSTA (2011), which includes those living in temporary accommodation and insecure housing. Consequently, estimates of the number of people experiencing homelessness in Ireland is somewhat limited since many who would be included under the FEANSTA definition are excluded by current enumeration techniques. Furthermore, the Department of Planning, Housing and Local Government (DPHLG) changed the way in which homelessness was recorded in 2019, excluding those in ‘own door’ accommodation and therefore lowering the overall numbers of homeless (DRHE 2019; Focus Ireland 2020).

Recent housing policy (Rebuilding Ireland) on centres on a ‘whole of Government’ approach to homelessness, with five key pillars including addressing homelessness. In order to achieve this, the plan sets out to provide additional healthcare and support services to address addiction and mental health in addition to the other issues (such as relationship/family breakdown, domestic violence, economic instability, rent arrears and tenancy issues as well as anti-social behaviour) which instigate or prolong homelessness. The plan involves the co-ordination of inter-agency supports for people currently experiencing homelessness. Other pillars include the acceleration of social housing, the building of more homes, improvements in the rental sector and the use of existing housing (Rebuilding Ireland 2020).

Drivers for Homelessness

The main drivers of homelessness are associated with individual (relationship breakdown, mental health issues, substance misuse, domestic violence) or structural (lack of affordable housing, loss of employment and poverty) factors or a combination of both (Focus Ireland 2020).

Housing is identified as an important non-medical, or social, determinant of health in that the health and future health outcomes of individuals are directly impacted by the conditions of their daily lives and the level of resources available to them (Whitehead and Dahlgreen 1991). Inequalities in these areas lead to inequities in health (WHO 2013).

A recent Irish study has found that people experiencing homelessness are more likely to utilise healthcare in a sporadic and unplanned manner. Compared to housed individuals, they have a higher utilisation of acute hospital emergency departments and subsequent admission in order to access medical care in the 25 to 65-year age group (Cheallaigh et al 2017).

In contrast with some studies, research in Australia found that people with mental ill-health do not normatively accept homelessness, but instead are pragmatic because they have few housing options, limited income and family support (Johnson and Chamberlain 2011).
There is a need to provide support to allow people with enduring mental illness to independent living. HAIL, which is a non-profit voluntary organisation set up in the mid-80s, identified a need for a greater level of supports for single, socially vulnerable persons, primarily with a mental health difficulty. HAIL has a team of community-based Mental Health Tenancy Sustainment staff who work with individuals, based on their needs, to support them to live independently within the community (HAIL 2020).

2.2 The Prevalence of Mental Illness, Substance Misuse and Homelessness in Ireland

Estimating the prevalence of mental illness in Ireland is difficult due to the lack of a coherent pathway for engaging with services as well as the stigma associated with mental ill-health. However, there is evidence that these problems are significant and growing. Almost 20% of young people (aged 19-24) and 15% of children (aged 11-13) have, at some point in their lives, experienced a diagnosable mental health illness. There has also been a 'alarming' increase in the number of adults disabled by a mental health issue, with numbers increasing by nearly one third (28.7%) between 2011 and 2016 (Mental Health Reform 2018).

The true level of prevalence for substance use in Ireland (or elsewhere) equally is unknown since the available figures are derived from analyses of data from a number of routine sources (criminal justice, drug treatment, mortality and morbidity). These sources exclude people who do not feel they have a substance misuse issue (i.e. see their use as purely recreational) or who may never have been engaged with the criminal justice system (NACD 2003). However, substance misuse has been on the rise in Ireland since 2013, with three in 10 adults reporting illicit drug use in their lifetime (as opposed to 2 in 10 in 2003). Substance misuse Is more common in males than females and more common in younger than older age groups (EMCDDA 2019).

Analysis of drug use, based on the National Drug Treatment System over a seven-year period from 2013 to 2019 (O'Neill, Carew and Lyons 2019) indicates that opioids (mostly heroin) was the main problem drug reported for treatment in Ireland in 2019 but is in decline. This is followed by cocaine (24.0%), cannabis (37.8%) and benzodiazepines (10.1%). The majority of cases for treatment reported poly-drug use (58.5%), and of these alcohol (37.3%) cannabis (37.0%) and cocaine (32.9%) were the most commonly reported additional drugs. There has been an increase in the proportion of cases for drug treatment within the homeless population, rising from 6.5% in 2013 to 11.0% in 2019 (O'Neill, Carew and Lyons 2019).

Similarly, accurate figures for the numbers experiencing homelessness are fraught with difficulty. The figures for August 2020 indicate that 4,204 adults were currently homeless in Dublin – 64.1% of which are male, with 35.9% female. These figures do not include family homeless numbers. The largest age category for single homelessness was in the 25 to 44 age group, which accounted for 57.0% (n=2432) of the total number of homeless presentations (DPHLG 2020). These individuals are accommodated in a number of different emergency accommodation types, including private emergency accommodation (PEA) such as hotels, hostels and B&Bs (n=2334), supported temporary accommodation (STA), i.e. hostel with support staff (n=1,879) and temporary emergency accommodation i.e. hostel without support staff (n=34) (DPHLG 2020). While women are more likely to experience environmental deprivation, they are less likely to be homeless than males (Grotti et al 2018). However, their experience of homelessness is different, and they often find themselves in homeless services which leaves them vulnerable to various kinds of abuse by a predominantly male homelessness population (Depaul 2020).

Research in Dublin's North East Inner City (where there are high levels of substance use and homelessness accommodation) found that standards of care varied hugely across private emergency accommodation providers. The report noted that staff training was often absent, leading to distress amongst residents who also felt fearful of making formal complaints for fear of eviction or discrimination (ICON 2019).

2.3 The Complexity of Mental Health, Substance Misuse and Homelessness

Mental ill-health, substance use and homelessness issues are in many cases often inextricably linked. Recent qualitative research in Ireland outlines the complexity of the issues, noting that while one difficulty may appear to influence the onset of another (or vice-versa) it is also the case that once in motion, there is a non-linear relationship between mental health, addiction and homelessness. Each factor has a role to play in contributing to the subsequent onset or exacerbation of the other (Murphy, Mitchell and McDaid 2017).

The numbers of people becoming homeless as a result of an addiction issue rose by almost one-fifth between 1997 and 2013 and the proportion of people in homeless services who reported drug use increased from 29.0% in 1997 to 80.0% in 2013 in Ireland (Glynn et al 2017). Equally, people in homeless services (hostel accommodation) can become involved in drugs and alcohol for the first time (Merchants Quay Ireland 2017). Homelessness can often be a trigger for an increase in drug use, even among those in stable OST programmes (Mayock, Butler and Hoey 2018).

Policy response is to focus on a 'Housing First' Model for those with complex health needs, and the HSE has embarked on an integrated approach to homelessness and addiction using a Service Reform Fund which aims to provide an integrated approach by the a number of key stakeholders (DHPLG, Local Authorities, Department of Health, HSE) in line with policy on housing, which supports a Housing First approach (HSE 2018). However, in the absence of an adequate supply of social and/or affordable housing, this policy has not been fully implemented (Social Justice Ireland 2020). Housing First initiatives have shown evidence that dual-diagnosed adults can remain stable in housing without increasing their substance use (Padgett et al 2006).

Merchants Quay Ireland and HSE ACCESS

Both Merchants Quay Ireland and the HSE ACCESS Team work with people who experience mental health difficulties, substance misuse and/or homelessness, or any combination of all three.

The ACCESS team was set up in 2004. It is a mental health service for homeless people that uses a multidisciplinary approach. The team comprises of a social worker, occupational therapist, psychologist as well as mental health nurses and psychiatrists. The goal is to treat homeless people with severe and enduring mental illnesses (such as Schizoaffective Disorder or Schizophrenia) who may or may not also be experiencing substance use issues.

Outside of statutory agencies, Merchant's Quay Ireland is an NGO operating in Dublin (formally since 1991) to provide care and support to homeless people, substance users and their families. By the mid-1990's, the Merchant's Quay service comprised a range of supports across a number of locations in Dublin City. They include day programmes, drug-free rehabilitation programmes, needle exchange as well as counselling and a meal service. By 2012, all of the various services were brought under one roof at the newly refurbished Riverbank Open Access Centre on Merchants Quay.

2.4 COVID-19 Declaration of a Pandemic

The World Health Organisation (WHO) declared COVID-19 as a pandemic by on March 11th 2020. This led to quite dramatic organisational change in the delivery of healthcare in Ireland, coinciding with a wide range of COVID-related restrictions introduced by the Irish Government beginning on March 27th 2020. Early on, particularly vulnerable groups were identified across the country and including individuals living in care and nursing homes as well as hospitals and those deemed most at risk – people with underlying health conditions and older age groups (HSE 2020).

Experiencing unprecedented interruption as a result of the COVID-19 pandemic, healthcare delivery in Ireland in both acute and community settings has been severely affected. While the initial anticipated surge in COVID-19 transmission was flattened as a result of close adherence to public health advice, normal services have not been reintroduced (December 2020), leaving those more vulnerable without many of the day-to-day services they depend upon, especially those in situations of homelessness, experiencing mental health and/or substance misuse issues (HSE 2020).

Throughout Ireland, homeless people were identified as an especially vulnerable group as a result of their living conditions and high morbidity levels, often accompanied by substance misuse (Keogh et al 2015).

Homeless people generally have significantly higher mortality rates than the general adult population, and Irish studies point to higher rates of addiction as well as poorer physical and mental health among this cohort (O'Reilly et al 2013). There is also a high prevalence of mental health disorders among the homeless (especially those residing in hostels), and this is often coupled with substance use issues (Prinsolo, Parr and Fenton 2012). The needs of homeless people with mental health issues are significant, with over half of this cohort reporting a diagnosis of depression and nearly one-third having expressed suicidal ideation (Glynn 2015).

Substance use issues are known to be a significant problem among homeless populations, and a history of substance use (or current substance misuse) is more likely to result in multimorbidity, according to a Dublin study of over 100 people experiencing homelessness in Dublin City (O'Brien et al 2015). The homeless substance using group in this research was five times more likely to report a poor quality of life than non-substance users. Health utilization, while high, was more likely to be of an informal nature through drop-in and call centres (O'Brien et al 2015). However, it is also evident that homeless people do not engage with health services in the same way as the general population, leaving them more vulnerable to serious illness (O'Carroll and Wainwright 2019).

Identified as a particularly vulnerable group due to these factors, a cohesive strategy was put together comprising homeless specialised General Practitioner (GP) services, harm reduction services in Dublin, the Dublin Homeless Executive (DRHE) and coordinated by the Social and Addiction Services of the Health Service Executive (HSE) (O'Carroll, Duffin and Collins 2020).

Mental Health Response to COVID-19

While the outbreak of COVID-19 necessitated a priority for healthcare resources to focus on the physical health implications of the virus worldwide (WHO 2020), there is a significant mental health impact related to COVID-19, which may have long-term psychiatric consequences for the general public (Torales et al 2020). Research from China (Xiang et al 2020) suggests that psychological and psychiatric care has been neglected in the context of COVID-19 and that this is of urgent concern for psychiatry. In particular, vulnerable populations (the homeless, people with disabilities, the chronically ill) tend to have an accumulation of risk factors, including poor physical and mental health as well as limited access to services and limited control on their everyday lives (Kelly 2020) .

Research conducted in China suggests that a whole-system approach needs to be taken, with additional training in mental health care provided to health care workers in hospitals, isolation units and within other services as a first priority. Additionally, this research notes that there is a need for specialised psychiatric treatments and mental health services for those with comorbid mental disorders, and a need for 'timely' psychiatric treatments for those with enduring mental health problems (Xiang et al 2020).

There is emerging evidence of changes in psychological well-being as a result of the pandemic in the general population which can in turn lead to increased stress levels (Matham et al 2020; Hamza et al 2020; Qiu et al 2020; Wang et al 2020).

A large-scale UK study found that high levels of anxiety around COVID-19 played a significant role in increased experiences of psychological distress, over and above generalised anxiety disorder (GAD) (Shevlin et al 2020).

Increased stress levels can be a factor in the development of, and relapse in, both substance and alcohol misuse (Brady and Sonne 1999; Sinha 2001). Such behaviours can be detrimental, especially in relation to COVID-19 infection, where both cocaine use and inhaled substances can create damage to the respiratory and cardiovascular systems, putting those with COVID-19 infections at increased risk of morbidity (Marsden et al 2020; Vardavas and Nikitara 2020) as well as decreased tolerance and subsequent overdose (Wakeman et al 2020).

Substance Use Response to COVID-19

The substance use response was rapid in the Dublin region, with an early recognition that people in active addition were less likely to be able to isolate or shield. Actions taken included rapid access to opiate substitution treatment (OST) and access to benzodiazepines (BZD) maintenance treatment for a number of people who regularly used benzodiazepines while in isolation or shielding. Another response involved the use of Naloxone, the drug used to counteract the effects of opioid overdose. The availability of Naloxone in Ireland is somewhat restrictive, necessitating risk assessment, training and the services of a doctor (usually a GP) (Clarke and Eustace 2016). On the evidence of staff working within the homeless services even before COVID-19, it was clear that a number of people who had overdosed had not been able to access Naloxone (Lyons 2014). As a result, continency guidelines were drawn up so that all individuals engaged with treatment providers could potentially be offered a supply of Naloxone and encouraged to use it where necessary (by a person trained in injectable product) (HSE 2020).

Homelessness Response to COVID-19

The homelessness response in Dublin (via Safetynet and the Homeless Health Link Team) focussed on protocols for identification and testing for COVID-19 of homeless clients, after which the DRHE rapidly provided them with accommodation suitable for isolation. Those deemed especially vulnerable were moved to single occupancy accommodation to allow for shielding from infection, and many more were transferred to other sites in order to decrease occupancy levels and reduce the risk of spread of COVID-19. As a result of this combined effort, infection rates were very low with only 63 homeless people diagnosed and only one death – a mere fraction of what had been originally predicted (O’Carroll, Duffin and Collins 2020).

2.5 Social Issues in COVID-19

The key measures required to control the COVID-19 virus, including self-isolation, cocooning and quarantine, requires isolation and can have significant negative effects on mental health (Kelly 2020).

The effects of the impact of quarantine on psychological health centre around social isolation which can lead to feelings of frustration, boredom and low mood as well as stress and poorer sleep quality. There is substantial evidence from previous epidemics that quarantine has a detrimental effect on psychological health, especially amongst younger people with chronic illnesses (Mukhtar et al 2020).

A multi-wave study in Ireland was commenced in March 2020, conducted throughout the COVID-19 outbreak and is focussing on the psychological impact of the pandemic (Hyland et al 2020). Initial findings (based on data collected in late March) indicate that mental health problems were common among the Irish population, with 35% of those surveyed displaying clinically meaningful levels of depression, anxiety or post-traumatic stress that would indicate the need for clinical care (Hyland et al 2020).

In examining those most vulnerable to developing a mental health problem related to COVID-19, the research found that the most significant risk occurred in those who expressed higher levels of loneliness (Hyland et al 2020).

Reduced Social Connections and impacts on Mental Health

This higher risk of a mental health problem due to COVID-10 as a result of loneliness, while affecting the general population (Hyland et al 2020), is of particular significance to people who experience mental health problems, substance misuse or homelessness as their experiences of any one, or any combination of more than issue, leads to social isolation (Kelly 2020). Substance misuse is linked to disruption in family relationships, which often becomes permanent and is extremely stressful for family members (Copello et al 2010; Duggan 2007; Orford et al 2010; Rossow and Hauge 2004). Equally, caring for a person with mental illness affects family in a number of ways and can cause conflict leading to loss of close family relationships (Von Kardoff et al 2016).

A growing body of research recognises the influence of social relations in mental health and psychological well-being, and that those experiencing mental health place great importance on social connections (Wang et al 2017). Mental health service users report greater levels of loneliness and have smaller social networks than the general population (Clinton et al 1998) and there is evidence of an association between loneliness and suicidal behaviour, personality disorders and psychoses (Goldsmith et al 2008; Richman and Sokolove 1992; Deniro 1995). For those with enduring or severe mental ill-health, loneliness and/or social isolation can lead to higher levels of delusions and lack of insight (Garety et al 2001; White et al 2000).

Homelessness is also inherently linked with social exclusion (Van Stratten et al 2018) since many of the characteristics of homelessness (lack of housing, debt, lack of social support) are also viewed as components of social exclusion. Homelessness is recognised an extreme manifestation as a form of social exclusion (Fazel et at 2014; Vrooman and Hoff 2013; European Commission 2009).

2.6 A Return to Services

COVID-19, Telemedicine and the Digital Divide

A safe return to previous service delivery envisaged a three-phase re-introduction of health and social care services in a COVID-19 environment (HSE 2020). However, with the onset of constantly changing levels of restriction (December 2020), it is not clear if this will actually be actioned.

The disruption of access to services for people with addictive disorders is likely to increase the extent and severity of such disorders since they are impacted particularly severely by existing poverty, physical and mental health issues (Marsden et al 2020).

Noting the lack of face-to-face contact, services in other countries have adapted the approach to interacting with service users using technology, increasing patient advocacy, which has been directly linked to improved patient ownership of treatment (Columb et al 2020).

Where psychiatric services have moved online in attempt to continue a level of care for individuals with an alcohol addiction, this has been met with mixed results. Some clients report good engagement with, for example, telepsychiatry, while others express a preference for face-to-face or group counselling sessions to be re-established (Columb et al 2020).

Even in the event that telepsychiatry and telemedicine become widely available there is evidence that, potentially, many service users will not be able to interact due to what has become known as the ‘digital divide’. The move in Irish post-primary schools to online education quickly gave rise to evidence of ‘digital exclusion’ – that is, in many instances, those with lower coverage of high-speed broadband and lower average household incomes were less able to avail of on-line education (Mahon et al 2020).

Technological exclusion is not a new phenomenon, with evidence that the most educated in the population adopt newer technologies first and that, in the UK in 2018, ten per cent of the adult population were internet ‘non-users’. The lockdown strategies in the UK are serving to increase digital inequality with the closure of public libraries where people might typically access online resources. The move towards online medical appointments, bookings and prescriptions are all inaccessible to certain groups and, beyond that, it has consequences for well-being and mental health with the ability to be able to connect with other people seen as critical (Watts 2020).

2.7 Planning for COVID-19 into 2021

The HSE has signalled additional funding of €5.5m to improve services for people who are homeless and in addiction as part of its Winter Plan. Noting that those individuals experiencing homelessness and addiction are a vulnerable group with complex needs, the plan aims to continue protective public health measures already in place while expanding GP services for people living in emergency accommodation in Dublin and elsewhere and providing ‘continuity of care’ for individuals who may require emergency hospital treatment (HSE 2020).

Absent from this plan is consideration of how to meet the needs of people with mental health illness, who are likely to be more disadvantaged as a result of this pandemic (Cullen, Gulati and Kelly 2020). Already, research indicates the need for a ‘ring-fenced’ additional budget for mental health services to allow mental health services to build capacity and adapt in responding to the current pandemic (Holmes et al. 2020).

2.8 Study Aims and Objectives

People with mental health issues have traditionally been excluded from having a say in their own treatment. As the Mental Health Reform recommendations state: (2015: pp.9) ‘*Involvement of service users and their carers should be a feature of every aspect of service development and delivery*’.

This research aims to explore participants’ lived experience of the COVID-19 pandemic, particularly in relation to its perceived effects on their psychological well-being. In particular, the research aims to document and analyse the experiences of individuals who are engaged with services at MQI and as part of the HSE ACCESS programme, who are experiencing homelessness, mental health illness, substance misuse or any combination of the three.

The objectives are:

- *To identify the challenges experienced by people with issues around mental health, substance use or homelessness (or any combination of all three) that have arisen from the COVID-19 pandemic.*
- *To examine the factors associated with participants’ service experiences, especially at the time of lockdown and following the partial re-opening of services.*
- *To understand the perceived impact of these changes (lack of in-house face-to-face contact; closure of night café; move to outreach services; increased formality of contact) in terms of the mental health of the service users*

3.0 METHODOLOGY

This section outlines the methodological approach to the study, as well as the specific methods used. It also outlines issues around ethics and participant consent as well as a number of challenges related to the conduct of the study.

3.1 Research Design

This study uses a qualitative approach, which allowed participants to articulate their personal perspectives on the effects of COVID-19 on their lives, particularly in relation to their mental health. The was achieved by the use of semi-structured interviews, using open-ended questions which allowed the participants to move between narratives reflecting the complexity of their experience. This method of data collection places the participant front and centre of the research process, beginning with concrete data (in the form of interviews), and permits the presentation of that data in an explanatory way (Charmaz 2007; Corbin and Strauss 2014).

By allowing the research to focus on phenomena in a natural setting in order to understand how people manage their daily lives, this study's methodological approach allows participants to explain their social meanings in a way that reflects their lived experience (Miles and Huberman 1994; Rhodes 2000). Qualitative research is particularly useful in the context of mental health, as it allows for the emergence of new insights into poorly understood areas, such as developing an understanding of subjective experiences of mental disorders (Fossey et al 2002).

Recent Irish policy in both mental health and substance misuse encourages the participation of individuals who are in receipt of services to have an input into the planning and delivery of those services (Department of Health 2017; Department of Health 2020).

3.2 Sampling

Purposive sampling was employed to ensure that the sample reflected the broad demographic of service users who were in receipt of services from either MQI and/or the HSE ACCES programme.

To be eligible for participation in the research, individuals had to:

- Be over the age of 18 years;
- Be in receipt of services (in-house or through outreach) from MQI and/or HSE ACCES before and after the first COVID-19 lockdown (before March 2020);
- Have experience of mental health and/or substance use and/or homelessness before and after the first COVID-19 lockdown (before March); and
- Have the capacity to give informed consent

3.3 Recruitment and Consent

The study aimed to recruit between 8 and 12 participants (4 – 6 from each service). Access to the potential participants was granted by both MQI and HSE ACCES, who acted as 'gatekeepers' for the study. In MQI this was Head of Services and, at HSE ACCES, the Consultant Psychiatrist on the team.

While there is concern over the use of gatekeepers in social research, particularly research involving the participation of vulnerable groups where the gatekeeper provides a service to the participant (Broadhead and Rist 1976), access to the study participants would not have been possible without their co-operation.

In the first instance, gatekeepers were provided with a participant information leaflet (PIL) and a copy of the consent form (See Appendix 1) which outlined the aims of the study and explained what would be required of the participants if they agreed to participate, which allowed them to decide who they would invite to participate and provide with a separate, service users PIL (See Appendix 1). This PIL also stated that their participation, or a decision to decline the invite to participate, would in no way impact on their access to services. Potential participants were then given one week to decide if they wished to participate. When individuals indicated an interest in participating, the researcher either contacted them directly (with their permission) to set up a date and place for an interview, or arranged an interview facilitated by their support worker via Zoom or phone.

3.4 Data Collection

Data collection in the form of interviews was due to take place in October 2020. As access to the MQI building was limited, it was agreed that interviews with these participants would take place via Zoom only, facilitated by an outreach case worker. This allowed for the first two interviews to take place at Riverbank. However, a subsequent outbreak of COVID-19 within the MQI building meant that all access to the building ceased and interviews could only take place by phone/Zoom where the case worker was directly in contact with the potential participant at an outdoor location. In the event, and with the onset of a second lockdown, three interviews were conducted by phone, arranged by the researcher.

Interviews with the participants from HSE ACCES were conducted early in the month of October at their building in Parkgate Hall where the researcher and participant met in a suitable room with the requisite PPE in place. A subsequent national move to Level 5 restrictions in late October to curb the growing numbers of COVID-19 cases meant that no further interviews could take place at this location.

Service User Interviews

Prior to interview, the researcher explained the purpose of the research and the consent form was read out to them. Any further questions were answered at this stage and participants were reminded again that they could withdraw at any time, refuse to answer any question and reassured that this in no way would impact their access to services, either now or in the future. They were asked for consent to audio-record. Consent was taken by the researcher in the context of face-to-face interviews and by the case worker in the other instances. Signed consents were posted to the researcher.

The interview schedule (See Appendix 2) comprised a series of open-ended questions covering a number of topics. These included a brief background chat to ascertain some biographical information as well as questions about their history of mental health/substance use/homelessness (as relevant). Interviewees' were also asked about the manner in which they accessed services, both before and after the first lockdown in March 2020, and how that has impacted the management of their day-to-day lives as well as how they felt it had affected their mental health.

For two interviews, participants were facilitated by their case worker who attended the interview and set up the Zoom call. The other eight were held in private; five of these interviews were conducted in person and a further three by phone. Interviews lasted for between 17.05 and 41.36 minutes, with the average duration being 27.1 minutes.

Data Analysis and Anonymisation

The interviews were transcribed verbatim and all potentially identifying information was removed from the transcripts. Each participant was given an alpha-numeric code and the data was fully anonymised. Each participant was assigned a pseudonym for use in the final report.

Interviews were analysed using NVivo 12, which is a qualitative analysis software package for the analysis of qualitative data. Double coding was applied to the data, where overall responses were used initially to code the data followed by the production of comparative nodes for further analysis. This provided a framework for emerging recurrent themes to be placed within coding frames which generated a lucid, synthesised and valid interpretation of the interview data.

3.5 Data Protection and Ethical Issues

In the absence of an accessible and expedient pathway to formal ethics approval, a number of experts the fields of research, homelessness, mental health and substance misuse were invited to form a Scientific Advisory Committee (SAC). Scientific Advisory Committees routinely advise (both formally and informally) and comprise members with expertise relevant to the area of study (CoPSAC 2011; Groux, Hoffman and Otterson 2018). At the study outset, an ethics application form in use by the Royal College of Surgeons in Ireland (RCSI) was completed to act as a guide for the study and sent to the SAC for review. In addition, a DPIA was drafted and issued for review to ensure that the highest standards of data protection were afforded to the study.

GDPR guidelines were strictly adhered to and all of the data gathered for the research was held in accordance with those guidelines. All computers and recording devices were doubled encrypted and stored in a secure location. Signed consent forms were stored in a locked filing cabinet in a locked office.

Working with vulnerable groups

A vulnerable group is defined as a number of people who share social characteristics that differentiate them from the general population in terms of poverty risk and social exclusion, such as people experiencing homelessness, addiction or with enduring mental illness (Frolich and Potvin 2008). However, as mentioned previously, recent Irish Government policy advocates the participation of such groups in allowing them to have a say in determining their own lives (Department of Health 2017; 2020). Research also indicates that taking part in research can be both positive and empowering for people within vulnerable groups and that it can be especially important in self-advocacy and helping to overcome social exclusion (Hall 2010).

Payment

No payment was offered for participation other than the offer to cover the cost of travel if needed. Participants were given a gift voucher for an Irish owned supermarket chain to the value of €20.00. This gift was not signalled in advance of securing individuals' agreement to participate and only issued following completion of the interview. It was therefore a way of thanking and acknowledging the time invested by participants in assisting with the study.

3.6 Challenges with the Study

Recruitment

Recruitment of participants from the HSE access service was relatively smooth because Parkgate Hall remained open during Level 3 three restrictions. Participants were comfortable with the space and, in many instances, scheduled an interview before or after meeting with another team member.

Recruitment of participants from the MQI proved considerably more difficult as face-to-face access to Riverbank was limited.

COVID-19

Recruitment started for this study in early October while Dublin was in Level 3 lockdown. This meant that access to Riverbank was limited. By late October, a Level 5 lockdown had been introduced eliminating any face-to-face contact with Service Users other than their case worker. This meant that subsequent interviews could be conducted by phone only.

Sample Size and Gender Issues

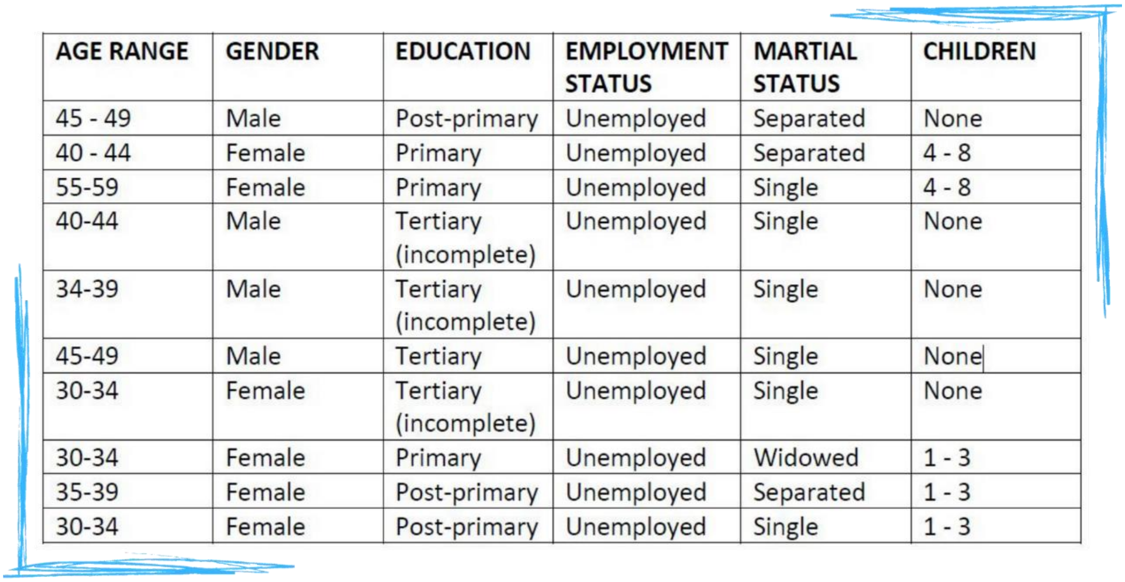
The initial aim of the project was to interview between 8 and 12 participants in generate an in-depth understanding of the effects of COVID-19 on the mental health of the participants. Qualitative research sample size is not concerned with making generalisations to a larger population but, rather, more inductive and emergent in nature (Charmaz 1999).
There is then, no ideal 'sample size' and, instead, qualitative research is more concerned with the concept of saturation which is the point at which the data collection process offers no new or relevant data (Mason 2010). This, coupled with the difficulties of carrying out research during a pandemic and the need for timely findings, led to the creation of this study using the input of ten participants.

Attempts were made by gatekeepers in both MQI and HSE ACCES to recruit a sample that was broadly representative of their service users (predominantly male). However, the end sample is predominantly female (a ratio of 6:4), reflecting a more widespread unwillingness on the part of men to engage in health research (Markanday et al 2013).

4.0 PARTICIPANT PROFILE

The following section provides an overview of the participants both from an sociodemographic point of view as well as a breakdown of their profile in terms of their mental ill-health, housing history as well as substance use, if relevant.

4.1 Sociodemographic Profile

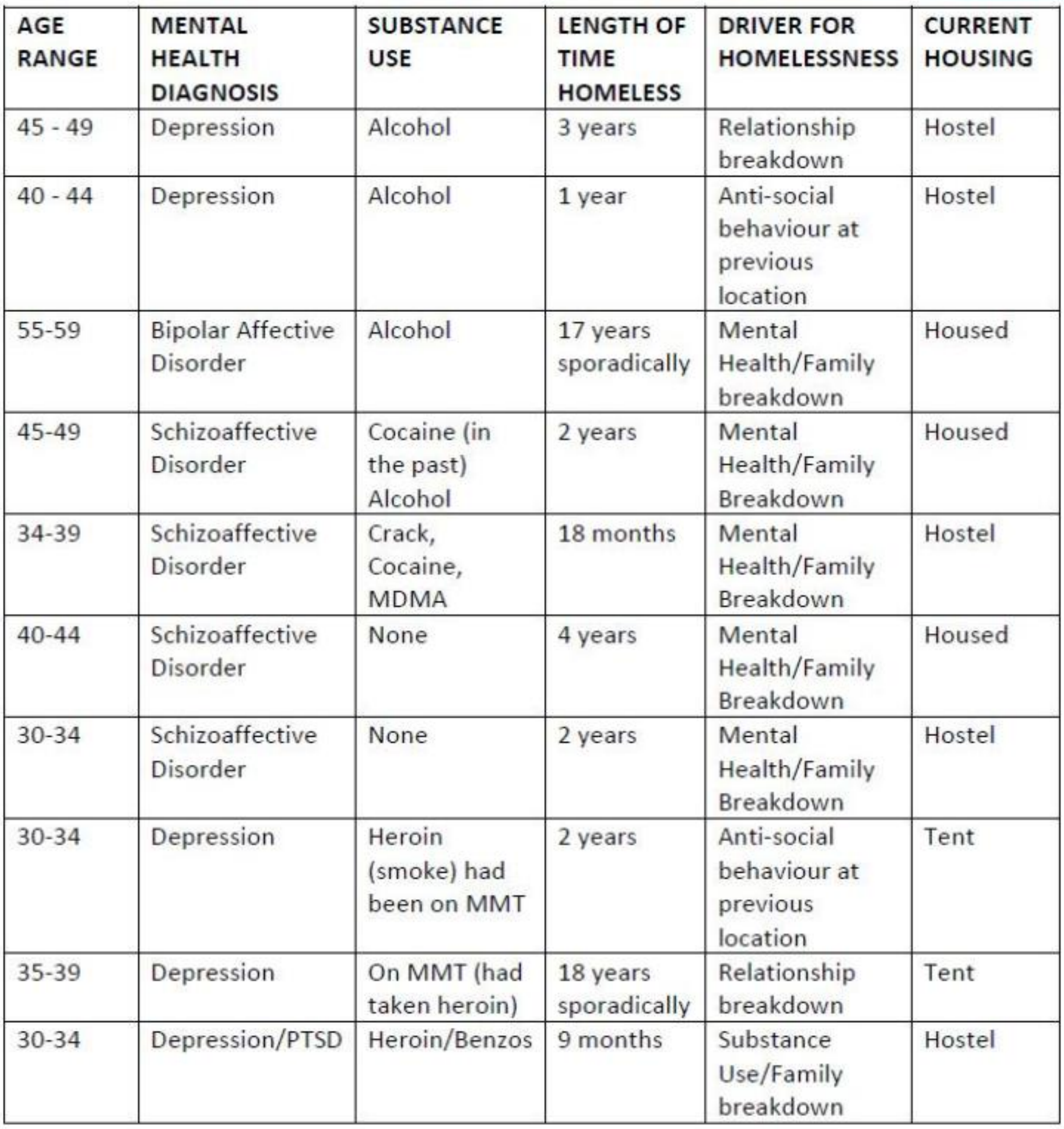


AGE RANGE	GENDER	EDUCATION	EMPLOYMENT STATUS	MARTIAL STATUS	CHILDREN
45 - 49	Male	Post-primary	Unemployed	Separated	None
40 - 44	Female	Primary	Unemployed	Separated	4 - 8
55-59	Female	Primary	Unemployed	Single	4 - 8
40-44	Male	Tertiary (incomplete)	Unemployed	Single	None
34-39	Male	Tertiary (incomplete)	Unemployed	Single	None
45-49	Male	Tertiary	Unemployed	Single	None
30-34	Female	Tertiary (incomplete)	Unemployed	Single	None
30-34	Female	Primary	Unemployed	Widowed	1 - 3
35-39	Female	Post-primary	Unemployed	Separated	1 - 3
30-34	Female	Post-primary	Unemployed	Single	1 - 3

Sociodemographic profile

Of the ten participants, four (n=4) were male and six (n=6) were female, with an age range of 32 to 58 years and an average age of 40.5 years for the sample. Three of the participants had achieved education to primary school level only, while three had completed their education to Leaving Certificate Level. A further four had gone on to third level education but the majority (n=3) had dropped out after a short period of time. All were unemployed at the time of interview, with one participant working in a voluntary capacity. Six of the participants were single, three were separated and one was widowed. Five of the participants in the study had children. For three of those mothers, contact with their children (cared for by family) continued by phone only during COVID-19 and for the other, whose children were in foster care, there was no contact. Only one mother, who was housed, had regular contact with her children.

4.2 Mental Health, Substance Use and Housing Profile



AGE RANGE	MENTAL HEALTH DIAGNOSIS	SUBSTANCE USE	LENGTH OF TIME HOMELESS	DRIVER FOR HOMELESSNESS	CURRENT HOUSING
45 - 49	Depression	Alcohol	3 years	Relationship breakdown	Hostel
40 - 44	Depression	Alcohol	1 year	Anti-social behaviour at previous location	Hostel
55-59	Bipolar Affective Disorder	Alcohol	17 years sporadically	Mental Health/Family breakdown	Housed
45-49	Schizoaffective Disorder	Cocaine (in the past) Alcohol	2 years	Mental Health/Family Breakdown	Housed
34-39	Schizoaffective Disorder	Crack, Cocaine, MDMA	18 months	Mental Health/Family Breakdown	Hostel
40-44	Schizoaffective Disorder	None	4 years	Mental Health/Family Breakdown	Housed
30-34	Schizoaffective Disorder	None	2 years	Mental Health/Family Breakdown	Hostel
30-34	Depression	Heroin (smoke) had been on MMT	2 years	Anti-social behaviour at previous location	Tent
35-39	Depression	On MMT (had taken heroin)	18 years sporadically	Relationship breakdown	Tent
30-34	Depression/PTSD	Heroin/Benzos	9 months	Substance Use/Family breakdown	Hostel

Five (n=5) participants reported a severe mental illness and, of these, a majority (n=4) had been diagnosed with Schizoaffective Disorder, with one having a diagnosis of Bipolar Affective Disorder. The remaining five participants had experienced depressive illness throughout their lives. One participant has recently been diagnosed additionally with Post Traumatic Stress Disorder (PTSD), having recently witnessed a violent death.

Two participants had a severe mental health issue with no co-presenting substance use history. Four participants had a mental health issue co-presenting with alcohol use and the remaining four had co-presented with substance use either at the time of the study or in the past. Reported substance use including cocaine and MDMA (in the past), heroin, benzodiazepines and crack at the time of the study.

All participants had, or were at the time of the study, experiencing homelessness. At the time of interviews, three were housed, while a further two (n=2) were sleeping rough (living in a tent). The remaining participants (n=5) were living in hostels. Time spent homeless ranged from nine months to eighteen years, with an average length of time homeless just over five years.

The majority (n=8) of the study's participants had entered into homelessness as a result of family or relationship breakdown which arose because of their severe mental health difficulties and/or substance use. Two had surrendered their previous rental properties because of anti-social behaviour in their area.

5.0 FINDINGS

This Section presents the views of the study’s participants on their mental health, substance use and housing – firstly in terms of their lived experiences of these issues and the challenges that they present. It also examines the factors around these issues in terms of access to services both pre- and post-COVID-19. In doing so, its aims to provide their understanding of the impact that the restrictions have had on the participants in terms of their mental health, substance use and housing. The section concludes by examining participants’ capacity for engaging with services in the future and explores what they feel would be most beneficial for them going forward.

5.1 Challenges to People With Issues Around Mental Health, Substance Use And Homelessness

The Threat of COVID-19

Social isolation, housing and limitations around access to services as well as services needed for daily life (food, shelter, washing facilities etc) were the main concern of all of the participants when asked about their experience of COVID-19. There was little discussion by them around the threat that contracting COVID-19 presented, with only three of the ten referring to the possibility of a direct threat to their own health.

David, who had an underlying medical condition related a decision, with his psychiatrist, to not attend for counselling in person as a result of his increased risk. For Sean, the reality of COVID-19 had been distant until recently, as he explained:

‘I am worried [about catching the disease]… just in the last couple of days. I just got word on my (young relative) - she was diagnosed with COVID. I just text my brother and he says she’s symptom free at the moment. But it’s an awful worry.’
{Sean, aged 35-39 years)

Roisin, who had been in a shared room now had her own room but was concerned about the number of people in the hostel as well as the fact that she had to share a bathroom:

‘There’s 10 girls. And I’m sharing a bathroom. I don’t like it. There are [rooms] with en-suites but I don’t have one.’
(Roisin, aged 30-34 years)

Nine of the ten participants referred to their own hygiene routines when asked specifically if they could manage to follow the HSE guidelines on mask wearing, hand washing and social distancing.

Miriam, who is street homeless, feels she is in control of the situation in spite of having to fund her PPE products from her own limited resources:

‘I always have me wipes and my hand sanitiser and all. Little tubs … and me face mask. I’ve all that. I do get that regular now, so I do. I do buy that myself now yeah. And it costs a lot of money.’

(Miriam, aged 30-34 years).

Peter felt that there was sense of combined effort in attempts to combat COVID-19, and mused that he felt there were some positives to be taken from health measures.

’Now everybody is socially aware of their own capability of passing on a disease. So that’s a good thing … because we’re used to it now, wearing a mask, washing our hands and socially distancing. You know everybody is. So that’s amazing that there’s a community feeling there as well, where people are all coming together to try and beat this virus.’

(Peter, aged 40-44 years).

Mental Health Challenges

All ten participants reported a mental health issue. Half (n=5), despite their diagnosis of a severe, or enduring, mental illness was not identified during their developing years in spite of their clear difficulty in functioning in terms of education, employment, friendships and/or family relationships.

One participant, who has a diagnosis of Bipolar Affective Disorder, talks of a number of attempts to take her own life from adolescence to recent years:

‘I’ve often taken overdoses – any sort of drug as long as I thought I was going to die. Just family problems. I used to get socially mixed up, you know? And then I’d end up in prison for public order offences.’

(Margaret, aged 55-59 years).

David, who was diagnosed with Schizoaffective Disorder, recounts a similar experience:

‘I tried to commit suicide a couple of times – I was in and out of hospital.’

(David, aged 35-39 years).

Both Margaret and David said that because they also had a substance use issue, that was the focus of treatment in hospital. For Margaret, the issue was alcohol:

‘I was often told I was an alcoholic and I’d end up in some alcoholic centre and … the psychiatrist would only be trying to get rid of you.’

For David, it was his cocaine use that led him to seek addiction support, with psychiatric illness being diagnosed at a much later stage.

Peter, who has been diagnosed with Schizoaffective Disorder, explained that he always felt ‘out of synch’:

‘I’d say I was always a bit different like. Even when I was in school, I wasn’t functioning as well as other people. I ended up in the lower classes – I was very disappointed in myself and … I had no one to talk to. I didn’t have any outlets to discuss it and try and regain it. So, I gave up on school in first year.’
(Peter, aged 40-44 years).

Similarly, Roisin recounted having had a difficult time at home from her teenage years:

‘I had a very bad relationship at home. I didn’t do well. I think I was depressed early on. When I was in my 20s, I was diagnosed bipolar but more recently [since I linked in here] it was Schizoaffective Disorder.’
(Roisin, aged 30-34 years).

For those with less severe, but still debilitating mental illness, all five suffer with depression, and have done so for most of their lives. Depression in most cases (n=4) had been a result of, they felt, challenging childhoods, as Pauline and Sandra explained:

‘I grew up...watching me da being abusive me ma and eh me da killed himself when I was 14 and that. So, it was just a mixture of things you know?’
(Pauline, aged 40-44 years).

‘My parents…I come from a broken home ... my mother was a manic depressive and my father was a raging alcoholic. And he used to beat my mam and things like that.
(Sandra, aged 35-40 years).

Substance Use Challenges

Two participants had no history of substance misuse. Of the eight remaining participants (n=8), three (n=3) had an issue with alcohol and five (n=5) with drugs. Substances used included heroin (n=2), heroin and benzodiazepine (n=1), cocaine (n=2), MDMA (n=1) and crack cocaine (n=1). Three of the participants had been in receipt of methadone maintenance treatment in the past (MMT) for their heroin use.

‘For the last 2 years now I’m actually going strong kind of, you know that way? On my methadone. Now don’t get me wrong, I’ve had a couple of slips. I ended up getting very bad again on the drugs. I used to be tablet dependant, like on benzos, but I detoxed myself off them.’
(Sandra, aged 35-40 years).

Both Sinead and Sandra had also been on MMT at some stage but were no longer, while David had taken cocaine in the past but was drug-free for a number of years.

Sean talked of recovering from his drug use (cocaine and MDMA) while in a detoxification facility outside of Dublin and how much of a positive impact it had on his life:

'I went to live in a community for drug addicts…I was there about three months. Everyone kept saying to me that it was tough, but I knew I needed it. It brought me back to life. It turned the light back on inside me you know?'
(Sean, aged 34-39 years).

Housing Challenges

Only three (n=3) of the study's participants were securely housed and all of these reported a severe mental health illness. Of the remaining participants (n=7), five were living in a hostel (two of whom had a severe mental health illness), while two were sleeping rough (living in a tent) at the time of data collection.
Drivers of homelessness for half of the participants (n=5) were related to family breakdown associated with severe mental health issues.

'Mum took a barring order out on me so I can't go home. I have a very difficult relationship with my Mum and Dad. I can't live at home – they don't understand and there's no support.'
(Roisin, aged 30-34 years).

'I went into homeless services here in Dublin … my Dad was elderly, and my family didn't want [me to live with father].'
(David, aged 45-49 years).

"I had a row with my Dad. And he'll call the guards, you know. So, I don't think they (parents) felt safe."
(Sean, aged 35-39 years).

'Well I fell out with my eldest brother and he kind of put me out. That was on the night of my father's funeral.'
(Peter, aged 40-44 years).

'Mostly it's due to psychiatric illness that I'm homeless, you know? Like I often ended up in prison with this illness.'
(Margaret, aged 55-59 years).

In two instances, participants had surrendered their accommodation because of anti-social behaviour.

'I was on my own with my daughter … it was a beautiful apartment, but then I was getting intimidated. One day I got a knock at the door in my apartment block and I opened the door and got a smack of a Budweiser bottle in the head. My apartment was broken into twice and I asked for a transfer and they [Council] told me I'd be better off announcing myself homeless in town.'
(Sandra, aged 35-40 years).

Sandra referred to the issue of intergenerational homelessness, explaining that she had entered into homelessness services as a young teenager when her mother left an abusive relationship.

'I didn't want to bring my daughter to hostels…to have the life I've had so I asked her (paternal) grandparents to take her. I was told I'd only be waiting a year but that was seven or eight years ago, and I still haven't been rehoused.' (Sandra, aged 35-40 years).
Sinead described a similar experience: *'I'm all me life homeless. I never got my own place. I'm 18 years homeless now.'*
(Sinead, aged 30-34 years).

5.2 Experiences of Pre-COVID-19-19 Service Use

Before the onset of COVID-19, half (n=5) of the participants were linked in with HSE ACCES for medication, counselling, health and occupational therapy on a face-to-face basis. In four (n=4) instances, participants were linked into this service directly following hospital admission, and had been supported to continue, where relevant, to engage in their local community either through supported employment, volunteering or as part of community engagement programmes. While appointments for formal services were routinely organised in advance, participants were welcome to call in at other times for assistance or just for a chat.

'You could come in and ask to see the doctor or something … they'd be able to look for anything you [needed] … like that. No problem. I could chat to all of them [the ACCES Team].'
(Margaret, aged 55-59 years).

The remaining participants (n=5) were predominantly linked in with MQI for a range of services, including counselling, substance use services, general health, social contact and personal hygiene services (showering, clothes washing facilities) and food.

'Going to the doctor, going to counselling, getting food – time out to myself there.'
(Sinead, aged 30-34 years).

Sean had started with MQI and was further referred to HSE ACCES: *'I started off, just using it for sleeping and the I got to understand what was going on there. And then I got counselling for two sessions and then she referred me to [HSE ACCES].*

'It was here I got a proper diagnosis and was started on medication and got counselling and help.'
(Sean, aged 34-39 years).

On occasion when no beds were available in hostels, they could stay for the night. Pauline described MQI as a 'home' where she could feel safe:

'When I was first homeless, I used to feel safer here at night, sleeping here than in a hostel. I used to come in and have …dinner and chat to the mental health staff, all the staff here … can recognise if you're not your normal self and … if you need to talk they'll bring you into a private room and have a chat with you to make sure .. let you know that they're there for you.'
(Pauline, aged 40-44 years).

5.3 Experiences of Post-COVID-19 Service Use

The declaration of COVID-19 as a pandemic led to the cessation of most businesses and services across the country. Within HSE ACCESs, the COVID-19 restrictions meant that the informal element of contact ceased. Margaret explained the impact of these restriction, describing her interactions with service providers as more 'more clinical', with 'not very much openness':

'It's very … you know. Clinical. You wear the mask and there's not very much openness you know? It's all changed. It's all "wait outside" and "we'll let you in as soon as the person comes".'
(Margaret, aged 55-59 years).

For David, who has an accompanying physical condition that put him at higher risk in the event of contracting COVID-19, the change was stark:

'I mean I was basically not seeing anyone. I'd get a phone call now and then from my psychologist and because COVID-19 was new, people didn't really know how to deal with it or handle it and services were just adjusting themselves. [And because of his medical condition] I just kind of agreed with my psychologist that I should just stay at home. To be honest, I was fine at first but then – yeah – I missed the interaction.'
(David, aged 44-49 years).

The HSE ACCES team subsequently place outreach services which participants found to be very beneficial.

Sean explained that if he missed an appointment, one of the team would phone him to see how he was doing, which made him feel cared for. Peter continued to volunteer, which kept him busy but he also benefitted from HSE ACCES outreach contact:

'I had [name] from here – she was always ringing me and would always arrange to meet me to go for a walk and things like that. She just kept me reassured and she was always there for me if I needed her. Outreach is important, yeah, definitely.'
*(*Peter, aged 40-43 years).

MQI also experienced a restriction of services during the first lockdown and had to close access to the building which meant that food, personal hygiene services and overnight stays (via the Night Café) were not available. Other services were available through the Homeless Health Link Team. GP services continued to COVID and saw between 30 and 40 patients daily. Their service users discussed the value of outreach, which was implemented by MQI in May 2020:

They come up basically every morning to me to see how I'm doing more or less. It's brilliant that way – it's nice to see different faces as well.'
(Sinead, aged 30-34 years).

'The staff [outreach] they'll see you and stop and ask if you're alright like. They're on a nighttime sweep and I'll bump into [Outreach Team member]. You can call down like but unless you have to link in with someone, you're not allowed into the building – but they'd come out and talk to you if you need them.'
(Michael, aged 45-49 years).

'Not being able to drop in is – yeah. The staff here are like my family … I've been coming here since and they are like a family to me. The support they give and all that.'
(Pauline, aged 40-44 years).

Miriam had been a regular attendee at MQI for drop-in services, but had since stopped because of limited access to the building and the need to make an appointment in advance:

'when you could get into the place it was excellent, but you can't do that because of COVID-COVID[but] they're still out on the streets after …and they're still doing needle exchanges and still giving out food and they're still ringing … still checking in on us.'
(Miriam, aged 30-34 years).

Lack of access to the building also meant that participants who were street homeless (as in the case of two participants, Sandra and Sinead, who are living in tents) had nowhere to toilet, shower and wash clothes. Their access to hot food was often sporadic as Sandra explained:

‘You can’t wash, you can’t shower, you can’t go to the toilet. Or even the simplest of things like a cup of tea in the morning you know what I mean?’

‘I get by with the soup runs at night. Well, there’s some days … I didn’t have anything all day long … I’d do anything for you know a proper dinner of potatoes, bread and a bit of meat. It’s that long since I had a dinner like that. So, [homeless charity] are giving out dinners… for free but if you don’t get down in time there doesn’t be enough.

‘There’s two soup runs that come around every night … and the majority of the week they do have hot… like in little pots. But sometimes by the time they get to you it’s freezing but you’d still eat it cause it’s the proper food. Like last night I got a bolognaise off them, but it was cold, but I didn’t mind. I still milled it cause I hadn’t had a dinner all weekend.’
(Sandra, aged 35-39 years).

Six of the ten participants had noticed an increase in the threat level on the streets as a result of the restrictions and limited resources. Miriam, for example, talked of the high levels of tension on the street and the difficulty of living in a tent*:*

‘The way the homeless are being treated at the moment is horrendous. It really is horrendous. I’ve seen people being spat on. They’re being set on fire. Their tents are being lit. The Gardaí are kicking them awake at 6 o’clock in the morning.’
(Miriam, aged 30-34 years).

5.4 Factors Around Social Connections and Isolation

All of the participants talked about feeling isolated. Of the ten participants, eight (n=8) had no or very limited phone contact with family either as a result of mental ill health or because of their substance use.

‘[The hardest thing about COVID-19 is] the social isolation with family and stuff. Like I haven’t met up with my siblings. I have been on the phone to a few of them, but I haven’t been invited out to their house or anything. I kind of notice that, you know?’
(Sean, aged 35-39 years).

Roisin had moved to Dublin a number of years previously to study and found living in the city very difficult, even before COVID-19, because of her mental health issues:

‘I was trying to study, and I couldn’t and then I didn’t want to go out anywhere at all. I was very isolated, I suppose, because I went to school [outside of Dublin] and then moved up here and I … couldn’t make friends easily. I find it very hard being on my own all the time.’
(Roisin, aged 30-34 years).

Pauline also described difficult social relationships:

‘Like for instance I went up to talk to my Dad and he says, ‘Oh I don’t want to know.’ And I don’t have friends.’
(Pauline, aged 40-44 years).

David explained that while he has friends, they do not meet up outside of social occasions.

‘You see most of my friends are drinkers. They like a few drinks. So, if we would meet up it would be in a pub and all the pubs are closed so we wouldn’t meet up.’
(David, aged 35-39 years).

Sinead described the absence of a relationship with her mother:

‘My mother, I don’t know, but she never wanted me, so my Dad reared me … and he died.’
(Sinead, aged 30-34 years).

Sinead’s children are living in care because of substance use issues and has had no access to them during COVID-19 restrictions.

Miriam similarly described intense loneliness:

‘So, for me the loneliness is the hardest part. I was missing my son [living with father], missing my partner at the time [who has since died].’
(Miriam, aged 30-35 years).

While all of the participants experienced social isolation, there was evidence of greater social interaction for the three (n=3) participants who were housed. David had been involved in volunteering activities and local support groups through HSE ACCES while Margaret was able to see her children regularly. Peter delivered groceries and provided care where needed to an elderly relative living nearby.

I visit my [relative] every Saturday. I do her garden and clean her house. I do a bit of work in her kitchen. I help cooking and do her shopping.’
(Peter, aged 40-44 years).

5.5 The Effects Of COVID-19 Restrictions on The Mental Health of Participants

For three of the five participants with severe mental health difficulties, social isolation, loneliness and the effects of the restrictions led to a deterioration in their mental health.

‘I had a bit of a setback with my mental health during the summer and I ended up in hospital. I guess I go through periods [with Schizoaffective Disorder]. It came to a head in the middle of lockdown [May]. I wanted to commit suicide and I wanted to go to [other country] to commit suicide for some reason … I left my phone behind me … and for some reason I came back to get it and here was some texts on my phone from my psychologist. And one of the texts made me question … maybe it was my thinking that was wrong and that maybe my psychologist who has always been supportive … [really is supportive].’
(David, aged 44-49 years).

Sean, who lost his job as a result of COVID-19, stopped taking his prescribed medication soon afterwards and starting to take MDMA. This triggered a relapse in his mental health and, following a row with his family who called the Gardaí, resulting in a three-month hospital stay to stabilise his mental health.

Roisin, who has Schizoaffective Disorder, described her heightened anxiety as a result of sharing a hostel room during the early stages of lockdown.

'When I moved here first, I had to share with three other girls – and two of them were heroin addicts and they used to shoot up in the room – they'd be injecting the heroin into their feet in the room in front of me. I was terrified. It was very distressing – I was crying my eyes out. It's been really tough.'
(Roisin, aged 30-34 years).

Half of the participants (n=5) had suffered with depression throughout their lives, and the onset of COVID-19 and the imposition of restrictions has exacerbated that depression, often paired with anxiety, and had led to suicidal ideation in the case of three participants. Sinéad talked about her own struggle in trying to overcome thoughts of suicide.

''I had thoughts coming cause I do suffer with depression …. I'm feeling [very vulnerable] And I know people do something and they don't talk about it, they just go off and do it [take their own life]. I don't want to do anything stupid.''
(Sinead, aged 30-34 years).

Miriam, who suffers with depression and PTSD, told that she found the lack of social contact has had a negative effect on her mental health*:*

'I go through days where my PTSD kicks in and I'm gone. You'd think I was off my rocker. It's the circumstances you're living in [not seeing anyone]. Just the way it makes you feel.' (Miriam, aged 30-34 years).

5.6 The Effects Of COVID-19 Restrictions on The Substance Use Patterns of Participants

For two participants (Michael and Pauline), the lockdown and the subsequent closure of pubs, has given them an opportunity to reduce their drinking. However, other participants who had a history of substance misuse (n=6), all had experienced either a return to drug use (or the threat of one) or an increase in substance use. Three who had been in receipt of MMT reported that they had returned to heroin use on one or more occasions.

'You can't stand still [in recovery]. You move forward or you move back. Whether you know it or not. Like I used [heroin] yesterday and I hadn't used in six weeks. It was a huge, huge blow for me you know, that I lost six weeks but at the same time it makes me very angry because if I'd got the help I needed … I wouldn't be in this situation.'
(Miriam, aged 30-34 years).

Seán, having completely detoxed from Cocaine and MDMA, started taking the latter after losing his job because of COVID-19 restrictions and, since moving into a hostel, his substance use has escalated:

'There's a lot of drugs around. It's hard not to get involved. There's just so many people doing it. When they're doing their pipe or crack or whatever, people always want to share. Out of one rock you'd get about 3 pipes, so you'd give one pipe away to share with someone. It's a social thing.'
(Sean, aged 35-39 years).

Sandra, who had been in recovery for the past two years on MMT, was struggling to retain that recovery:

'My health is deteriorating. I'm on the verge of going back on drugs and I don't want to. Because there's nothing there, there's no one there for me, there's no support for me.' (Sandra, aged 35-39 years).

Neither Sandra nor Miriam wanted to live in a hostel where they feel drug use is omnipresent, but these are their only options when a bed does become available. This sentiment was echoed by Seán and Roisín – Seán because it just becomes too easy to access drugs and fall back into old habits, and Roisín because she finds drug use *'terrifying.'*

5.7 Barriers to Engaging with Alternative Support

Participants were asked for their views on the possibility of online support for counselling and social contact in the event of continuing restrictions. Of the ten participants interviewed, three had access to mobile phones and/or laptops and had internet access. Of the remaining seven, four had mobile phones which had no internet access. Of those that did have internet accessible phones, three had no facilities to charge their phone.
Sean said he would prefer face-to-face counselling but, if that was not possible, he would be open to online counselling.

Pauline, who didn't have internet access, felt that online support was not a feasible option.

'I don't think it will work. You need someone to sit there and talk to. Unless the person really wants to as well. Some people don't have computers – they just don't you know?'
(Pauline, aged 40-44 years).

Both Sinéad and Sandra lived in tents and have no way of charging their phone.
'It's very hard to charge up the phone cause there's nowhere to charge them – the phone could be dead for weeks and that's it.'
(Sinead, aged 30-34 years).

Sandra explained that she's had several phones stolen and now only has one with no internet access: *'I charge it in the shop.'*

Miriam described her experience of an online counselling session, explaining that she found it of limited use:

'It was fine, but it wasn't the same. I know with COVID-19 you can't be near people, but I also had a counselling session that was face-to-face with somebody as well as that did me so much more than the online thing. Because you don't feel a real connection to that person. And [privacy] my partner was with me and you won't say … there's certain things you can't say.'
(Miriam, aged 30-34 years).

5.8 An Exploration of Needs going Forward

Of the ten participants interviewed, only three were securely housed. When asked what would be of most help to them going forward, there was a unanimous response in relation to housing, with all expressing a need for a stable base and a secure place to live:

'Even if I was just given a room with a door and windows, I'd be happy. You know what I mean? Just one room, I wouldn't mind, you know what I mean? Cause I've all my life to do it up.'
(Sandra, aged 35-40 years).

Roisin described her current living situation, which was in a hostel. Like others, she emphasised that have a safe and secure place to live would really help to make her feel less anxious:

'There are bedrooms with an en-suite, but I don't have one. The room is tiny – it's about half the size of this room so there's only room for my bed and my stuff. It's really isolating.
'Having my own place. That would really help. Just being away from drug users and that – I was so scared. Having your own place is really important – your own place where you don't feel vulnerable or threatened. But I don't know if I'll ever get anywhere to rent and that makes me really anxious.
'I've just done all the forms for HAP. But all they will give me is 990 … everything that looks decent costs about 2000 euro.'

Roisín felt housing was something which she will never achieve due to her illness:

'It makes me anxious – I mean I'm unemployed and I have a mental health problem – it's going to be very difficult – impossible – to get somewhere to rent. I don't think landlords will want someone on HAP or with mental health problems.
'I just wish there was more social housing for people like me. I was terrified living in the hostel, I have no space and can't cook good food and there's a lot of drug use, but I can't see myself ever getting a place of my own.'
(Roisin, aged 30-34 years).

5.9 Summary of Findings

Mental Ill-Health, Substance Use and Homelessness

Of the ten participants, half present with enduring mental ill health and five with depressive illness. Eight participants co-present with substance use, and in total seven are experiencing homelessness (5 are in hostels and 2 are street homeless.

Pre-COVID Service Use

Participants (n=5) who were linked into HSE ACCES report a welcoming service, structured but with an informal element.
Participants (n=5) who were linked into MQI report that it felt 'like home' an enjoyed unstructured access.

Post-COVID Service Use

As a result of service restrictions, participants found their service use to be more formal, clinical and structured. Both groups felt that outreach services were essential.

Loneliness/ Lack of Social Capital

All of the participants reported feelings of loneliness, abandonment and isolation. The majority (n=8) have limited contact with family and eight also report having no friendships.

Effects of restrictions on Mental Health

Of the five participants with enduring mental illness, 2 have required hospitalisation and one reports increased depression and anxiety. Of the five participants with depressive illness, all report increased depression, the majority (n=4) report increased anxiety and 3 report suicidal ideation.

Effects of restrictions on Substance Use

While two participants report reduced alcohol consumption due to closure of pubs, one reports increased alcohol intake. Four participants, who had been in recovery or drug free, report a return to substance use.

Capacity for Online support

Less than a third (n=3) have internet access, four have mobile phones with no capacity for internet access. Three participants have phones with internet capacity, but no access.

6.0 DISCUSSION

This section discusses the key findings arising from the research, which examined the experience of the participants, and the challenges faced by people in terms of mental health, substance use and housing on a day-to-day basis in the light of the COVID-19 pandemic and its subsequent impact on service delivery. The research also aimed to generate an understanding of the factors around these issues in terms of services and the effects this has had on their psychological well-being.

6.1 Challenges to People with Issues Around Mental Health, Substance Use and Homelessness

It is clear that mental health, substance use and homelessness are inextricably linked, with all of the participants (n=10) having experienced homelessness at some stage in their lives, either as a result of mental health issues, substance use disorder or a combination of both. There is ample evidence of the non-linear relationship between all three issues (Murphy, Mitchell and McDaid 2017).

Mental Health challenges

All of the participants in this study experienced mental health problems; half (n=5) of a severe nature (Schizoaffective Disorder/Bipolar Affective Disorder) and, for the remainder (n=5), all reported a clinical diagnosis of depressive illness (with one co-presenting with PTSD) at some point in their lives. All continued to struggle with depression and/or anxiety.
Amongst those who reported severe mental illness, accounts describe an early life characterised by a lack of support, understanding and clinical diagnosis, perhaps reflecting the limitations of mental health support in Ireland generally. This was particularly evident in participants' experiences in their younger years where the establishment of Child and Adolescent Mental Health Services (CAMHS) may have provided a timely route to intervention This is also true of the participants who experience depression, and have done so as young people, often as a result of violence or trauma in their home lives (Canon et al 2013).

Substance Use Challenges

The majority (n=8) of participants in this study reported the use of substances (alcohol or drugs) as well as living with a mental illness. For those with severe mental illness (n=5), one person had an alcohol dependency issue, while a further two (n=2) had used cocaine or MDMA in the past, and one was currently using crack cocaine. For those who reported depression, three had used heroin in the past, or were using heroin at the time of the study, while a further two reported an alcohol dependency. There was little discussion by the participants on support for tackling alcohol dependency, perhaps reflecting the lack of recognition of the harm caused by excessive alcohol use in terms of morbidity and physical health issues as well as poor mental health and suicide (Department of Health 2017; HRB 2014; 2016; 2018)

Mental Health and Dual Diagnosis

The lived experiences of these participants are in line with previous findings suggesting that there is a clear link between long-term substance misuse and mental health disorders (Iro and O'Connor 2009; Kamali et al 2000; Lyne et al 2010). Participants in this study reported having been referred for substance use issues while experiencing severe mental health issues, pointing to a lack of co-ordinated dual diagnosis service provision in Ireland (Proudfoot, MacGabhann and Phelan 2019).

Housing Challenges

All ten participants in this study had experienced homelessness at some point in their lives. As a group, they had been homeless for between nine months and 18 years, with the average duration of homelessness being just over five years for the sample.
At the time of the study, only three of the participants were housed, and all are representative of a group with a complex history of mental illness and/or substance use in need of considerable levels of support and a key target group for a Housing First approach (Social Justice Ireland 2020).

Drivers of homelessness for the cohort experiencing severe mental health illness (n=5) were associated with family breakdown in the majority (n=4) of cases, while one in this group had experienced relationship breakdown. Two of the participants in the group experiencing depression (n=5) (both of them single mothers) had surrendered their properties because of anti-social behaviour, while three participants linked their homelessness to substance use issues and subsequent family breakdown, two of whom had experienced intergenerational homelessness.

Homelessness as a result of substance use has increased year on year, and the proportion of people reporting drug use in homelessness services increased from 29.0% in 1997 to 80.0% in 2013 (Glynn et al 2017). Participants in this study who were living in hostels or on the streets reported widespread prevalence of illicit substances both on the street and in hostel accommodation, confirming earlier findings that homelessness can trigger increased drug and/or alcohol use (Mayock, Butler and Hoey 2018; Merchants Quay Ireland 2017).

6.2 The COVID-19 Pandemic and Changes in Service Delivery

The declaration of COVID-19 as a pandemic by the World Health Organisation (WHO) in March 2020 led to significant organisational changes in the delivery of healthcare in Ireland, affecting healthcare in both acute and community settings (HSE 2020).

The necessity for healthcare services to focus on the physical health implications of COVID-19 globally, while understandable, meant that the significant mental health impact of the pandemic was left largely unaddressed. The neglect of psychological and psychiatric care is of urgent concern, particularly for vulnerable populations, including the homeless, people with disabilities and the chronically ill (Kelly 2020; Torales et al 2020; WHO 2020).

All of the participants in this study are considered to be a vulnerable population under this definition, with some living with a severe mental illness to the point that it can be considered a disability, while most were homeless and have, or had in the past, a substance use issue.

Prior to the onset of the pandemic, half (n=5) of the participants were linked in with the HSE ACCES Team for medication, counselling and occupational therapy on a face-to-face basis. Three participants (n=3) had been directly linked into this service from hospital, while two had been engaged originally with MQI. All five had a diagnosis of a severe mental illness (Schizoaffective Disorder n=4; Bipolar Affective Disorder n=1). It is a very good reflection of the service that all of the participants talked of the informality of services and the welcome they received, even if they called in without an appointment.

Similarly, for the other five participants who were linked in to MQI at Riverbank, a number described this service as a 'home' where they felt safe. All of the participants commented on the importance of social interaction – and having access to a place where they could spend the day or evening (if they were street homeless or in a hostel and required to leave during the day), reflecting the importance they place on social interaction (Clinton et al 1998; Wang et al 2017).

With the onset of the pandemic, and the introduction of the first lockdown in March 2020, access to both buildings (Parkgate Hall for HSE ACCES and Riverbank for MQI) was limited. This unprecedented interruption in services severely affected healthcare delivery in Ireland in community and healthcare settings, and while the lockdown reduced transmission of the virus normal services have not yet been introduced, leaving those most vulnerable (those experiencing homelessness, mental health and/or substance use issues. Without the services that they depend upon on a daily basis (HSE 2020). Lack of access to their normal supports at both services has proved a particular challenge to the participants in this study.

6.3 The Effects of COVID-19 Restriction on The Mental Health of The Participants

This change in services for the participants in this study in the first wave of the pandemic have been stark with all the participants expressing feelings of abandonment, intense loneliness and isolation.

Since then, both MQI and HSE ACCES have put in place outreach services. HSE ACCES regularly phone and text clients to check in on them and engage them in physical activity where possible (meeting up for walks etc). They have also been able to continue to see service users on a one-to-one basis within Parkgate Hall, albeit in a more formal setting. Four of the participants are seen by their psychologist in this setting once a month, with regular informal communications (texts/video calls) in between.

However, for the participants, the initial closure of the service, coupled with their existing mental illness, led to a marked deterioration in their mental health in the case of three of the five participants with severe mental health illness which required hospitalisation mid-way during the first lockdown. One experienced a pattern of paranoid thinking which culminated in him contemplating taking his own life. This train of thought was interrupted by the timely intervention of a text message from his psychologist, which made him reconsider this decision, underlining the effectiveness of outreach.

For another participant, who had lost his job as a result of the lockdown, this necessitated a return to his family home (where he felt he was unwelcome). He stopped his medication, leading to a family row and his subsequent admission to a hospital facility. This resonates with previous research pointing to greater levels of loneliness leading to higher levels of delusion and lack of insight in those with severe mental ill-health (Garety et al 2001; White et al 2000).

One participant, who was living in a hostel where there is open drug use, found the experience terrifying and this had increased her depression and anxiety levels, on top of her existing diagnosis of Schizoaffective Disorder.

For the participants predominantly accessing services in Riverbank, the closure had resulted in increased levels of depression, often paired with anxiety, leading to suicidal ideation in three instances. This finding echoes previous research on the importance of social connections, the lack of which can lead to suicidal behaviour (Clinton et al 1998; Deniro 1995; Goldsmith et al 2008; Richman and Sokolove 1992; Wang et al 2017).

6.4 The Effects of COVID-19 Restriction on The Substance Use Patterns of The Participants

Within the general, largely healthy population, there is evidence of changes in psychological well-being, leading to increased stress levels because of COVID-19 (Hamza et al 2020; Matham et al 2020; Qiu et al 2020; Shevlin et al 2020; Wang et al 2020).

Even prior to the pandemic, the prevalence of anxiety and/or depression is common in the homeless population, whether or not they co-present with a substance use issue (O'Brien et al 2015). All ten participants in this study present with both a mental health issue and have at the time of the study, or in the past, experienced homelessness.

Previous research indicates that increased stress levels can be a factor in the both the development of, and relapse in, substance and alcohol misuse (Brady and Sonne 1999; Sinha 2001). In the context of COVID-19, this has the potential to lead to decreased tolerance and subsequent overdose (Wakeman et al 2020) as well as an increased risk of morbidity on contracting the coronavirus (Marsden et al 2020; Vardavas and Nikitara 2020).

Within this study, of the four participants who had previously been in recovery, or drug free, from substance use (heroin, n=3; crack = 1), three had experienced a relapse while one participant had increased his alcohol intake during the time of the first introduction of restrictions.

6.5 The Effects of COVID-19 Restrictions on Housing and Health

Homeless people have been identified as a particularly vulnerable group, with higher morbidity levels, poorer mental health and higher rates of addiction than the general population (Glynn 2015; Keane et al 2018; O'Reilly et al 2013; Prinsolo, Parr and Fenton 2012).

As a population, the homeless were deemed to be particularly at risk of contracting COVID-19 (HSE 2020), but also less likely, based on previous research on health care engagement patterns, to engage in formal health care and were more vulnerable to serious illness (O'Brien et al 2015; O'Carrol and Wainwright 2019).

As outlined previously, a cohesive strategy was drawn up which was formulated comprising General Practitioner (GP) services, voluntary and community services, harm reduction services and the Dublin Regional Homeless Executive (DRHE) which was co-ordinated by the Social and Addiction Services of the Heath Service Executive (HSE). This resulted in very low infection rates, with only 63 people diagnosed with COVID-19 and only one death – a fraction of what had been predicted in the first wave (O'Carroll, Duffin ad Collins 2020).

The homelessness response focussed on protocols for early testing, rapid accommodation to allow for self-isolation, and reduction to single occupancy rooms to decrease disease spread (O'Carroll, Duffin ad Collins 2020).

6.6 Social Issues in COVID-19

The key measure in controlling the spread of COVID-19 requires social isolation, which has negative effects on mental health, even within a healthy population (Kelly 2020). Lessons from previous pandemics suggest that the impact of quarantining can have a detrimental effect on psychological health (Mukhtar et al 2020).

Early results from a multi-wave study in Ireland has found significant mental health difficulties in the Irish (largely healthy) population requiring a need for clinical care, with the most significant risk occurring in those who expressed higher levels of loneliness (Hyland et al 2020).

Those experiencing mental health problems, substance misuse or homelessness (or any combination of the three) experience social isolation (Kelly 2020). Much of the dialogue of this study's participants focused strongly on this issue – indeed, when asked what the worst part of the restrictions were, all identified loneliness, lack of personal contact or social exclusion as the most challenging, with fear of contracting the disease much lower on their list of priorities.

Substance misuse and providing care to a family member with a severe mental illness is extremely stressful for family, often leading to conflict and a cessation or disruption in family relationships (Copello et al 2010; Duggan 2007; Orford et al 2010; Rossow and Hauge 2004; Von Kardoff et al 2016). This is borne out by the experience of participants in this study, with the majority (n=8) of the participants homeless because of family disharmony. This lack of family support and interaction was felt more keenly during the restrictions brought about by COVID-19, with participants citing lack of family support and engagement as a key driver for loneliness, with participants not being allowed to visit the family home during OVID-19 for example.. The lack of family support meant that they were more dependent on the open and welcoming nature of both MQI and HSE ACCES services, which they saw as their key alternative to family, again reflecting their need for alternative social connections (Clinton et al 1998; Wang et al 2017).

All five participants experiencing severe mental health illness became homeless as a direct result of discord with their family around their mental illness and a further three participants became homeless as a result of relationship or family disruption as a result of their substance use issues, which is evident in previous studies (Copello et al 2010; Duggan 2007; Orford et al 2010; Rossow and Hauge 2004; Von Kardoff et al 2016).

Homelessness is also linked with social exclusion and homelessness people represent the most extreme of the socially excluded groups in society (Fazel et al 2014; Van Stratten et al 2018; Vrooman and Hoff 2013; European Commission 2009).

6.7 Barriers to Engaging with Alternative Support

At the time of the start data collection for this study (September 2020) Ireland was out of its first lockdown and services had returned in many instances, albeit more formally and at a level of social distance for service users. The Irish Government subsequently rolled out a guideline for living with COVID-19 which listed a number of levels of shutdown based on increases in Coronavirus prevalence. Mid-way through data collection, Level Three was imposed on Dublin which meant that access to service users became more limited. By late October, Ireland was again in a version of lockdown at Level Five with services again severely curtailed and physical access to MQI a limited an option for service users. However, the GP service stayed open as normal and expanded its service from afternoons to both morning and afternoon to accommodate a trebling of patients on OST from 50 to 150 and to permit social distancing.

Originally, the HSE had envisaged a safe return to services with the introduction of health and social care services over three-phases (HSE 2020). However, with constantly changing restrictions, it is unclear if this is likely to happen in the manner originally envisaged. The impact of this will be that people with substance use disorders are likely to experience an increase in the extent and severity of their substance use, becoming more negatively impacted as a result of already existing poverty and mental health issues (Marsden et al 2020). For the participants in this study, four of whom were interviewed in the middle of the second lockdown, this is evident in their increased substance use or reversion to prior use, even having been in recovery for some time.

In some instances, psychiatric services have moved online (for alcohol addiction) but has met with mixed results while some other services have adapted their interaction, increasing patient advocacy (Columb et al 2020).

There is, however, a problem with what has become known as 'digital exclusion' or the 'digital divide' with evidence that the most educated of the population adopt newer technologies first. Typically, people without digital access would gain access in public spaces (public libraries) but they have largely been closed to the public since the onset of the pandemic. As a result, the move towards an online solution is inaccessible for many and has consequences for well-being and mental health with the ability to have a physical connection to another person critical (Mahon et al 2020; Watts 2020).

This was clear for the most participants in this study, has they had limited or no access to smartphones or laptops and had internet connection.

While those who were housed felt that online support would be helpful, in the absence of face-to-face support, the remaining participants (n=7) felt that this would not be a feasible option, citing the need to build a relationship with service providers and problems around privacy during a potential counselling session online, again in line with research underlining the importance placed by this cohort on social connections (Wang et al 2017).

6.8 Forward Planning For COVID-19

The winter plan for COVID-19 into Spring 2021 focusses on individuals experiencing homelessness and addiction, with the provision of a 'continuity of care' that will continue protective health measures and expand GP services for those living in emergency accommodation (HSE 2020).

Absent from the plan is consideration of how to meet the needs of people with mental health illness. Noting that people with established mental illness are more vulnerable to relapse, reduced functioning and exacerbation of symptoms, people with enduring mental illness are likely to be more disadvantaged as a result of this pandemic (Cullen, Gulati and Kelly 2020). Already, research indicates the need for a 'ring-fenced' additional budget for mental health services to allow mental health services to build capacity and adapt in responding to the current pandemic (Holmes et al. 2020).

Within Merchants Quay Ireland, and upon the reduction in face-to-face of services (including general access, food services, night café), funding from the DRHE ceased in March 2020. Working collaboratively with a HSE Health link team during the Summer of 2020 to help reach those in isolation, an assertive outreach team (AOT) started to link in with homeless people while a separate team worked on harm reduction as part of an outreach programme. This collaboration ended in late summer and, by early Autumn, MQI continued to provide three outreach teams – one to provide harm reduction care another to provide assertive outreach to the most vulnerable and one focussing on community engagement. While services had started to allow some access to their main base (Riverbank) from July to September. This was reduced again under a Level Five lockdown, underscoring the need for outreach programmes both now and in the future.

When asked what they felt would be of most benefit to them going forward, the majority who were not housed identified housing as their most urgent need. While this would also have been the case pre-COVID-19, the need has been exacerbated by the onset of the coronavirus with participants feeling more under threat on the streets, experiencing widespread drug use in hostels as well as having difficulties isolating in some instances.

7.0 CONCLUSION

This study had the following aims and objectives:

- *To identify the challenges experienced by people with issues around mental health, substance use or homelessness (or any combination of all three) that have arisen from the COVID-19 pandemic.*
- *To examine the factors associated with participants' service experiences, especially at the time of lockdown and following the partial re-opening of services.*
- *To understand the perceived impact of these changes (lack of in-house face-to-face contact; closure of night café; move to outreach services; increased formality of contact) in terms of the mental health of the service users*

Prior to the onset of the pandemic, and in the absence of social supports and/or networks, the participants in this study already experienced social isolation, placing them at higher risk of relapse in their mental well-being as well as at risk of increased, or reversion to, substance use. The level of isolation required to manage COVID-19 has served to increase that social isolation, leading to a marked deterioration in their mental well-being and their ability to manage their substance use.

The participants who live with severe mental ill-health, depressive illness and/or substance use had all experienced homelessness directly linked to those issues and, as such, are an extremely vulnerable group.

Their experience, and lack of correct diagnosis earlier in their lives (especially in relation to dual diagnosis) for mental health issues and substance use support is a reflection of a failure of policy to date to tackle mental health, substance use issues and homelessness at a cohesive level. The restrictions around COVID-19 have served only to highlight these failings and have exacerbated their mental health illness and in some instances a return to drug use, having been drug-free or in recovery.

As a result, and in the absence of services because of COVID19 restrictions which they, in many instances, viewed as a substitute for their absent social supports, both MQI and HSE ACCES act, as it were, 'in loco familia' – providing the support that is otherwise absent in their lives. This is not a support that can be easily substituted by technology.

7.1 RECOMMENDATIONS

This research cannot be said to be generalisable to an entire population; however, many of the findings resonate with existing and emerging literature on the very real need to attend to the psychological impact of the pandemic, particularly for vulnerable groups.

As a result, the recommendations include:

Ring fenced funding for mental health support at statutory, voluntary and community level

- This will allow mental health services to adapt and build capacity to better respond to needs during emergency situations such as COVID-19
- It will also allow services such as MQI to gain direct access to counselling services for those most in need as identified by staff.
- Needs to ensure that mechanisms are put in place to facilitate face to face engagement of health care practitioners with service users
- Needs to ensure that service users can engage with health care professionals without the requirement to have mobile phone or internet coverage - i.e. to make an appointment to see a key worker

Increased Outreach Staffing and Funding

- The levels of isolation experienced because of COVID-19, and the success of the existing outreach work both in MQI and at HSE Access, suggests that both staffing of and funding for outreach services needs to be increased in the immediate term
- There is also a need to for services such (community/voluntary and statutory) to provide an in-reach based service to hostels or those in private emergency accommodation

Establishment of Substance Free/Recovery Support Hostels

- Participants, particularly those with poor mental health, are in need of drug and alcohol-free hostels which support recovery which would provide more stability for service users
- Establishment of safe spaces for homeless women
- Gender specific services for women who use substances

Further Research

- Any and all planning for the development and delivery of services should have at its core the direct input of service users through formal consultation
- This research was carried out after the first lockdown and at the beginning stages of the second lockdown and the onset of winter. An extension to this study to follow up with the same participants would provide an invaluable insight into how they manage as the COVID-19 pandemic and related restrictions continue.

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APPENDIX 1

PARTICIPANT INFORMATION LEAFLET FOR CASEWORKERS

Study Working Title: An exploration of the impact of COVID-19 on the mental health of service users

What is the study about?

We are currently conducting a research study and would like your assistance.
This is a study about people who are accessing services for homelessness, substance use or mental health, and who may have had their services affected by COVID-19.

Why have I been asked to take part?

As a person who has been supporting individuals to access services, we are asking you to identify people who would be able to tell us of their experiences around the changes that COVID-19 had on their services as well as on their mental health and well-being.
The overall aim of the research project is as follows:

An exploration of the impact of COVID-19 on the mental health of service users.

Specifically, the research aims to document and analyse the experiences of individuals linked in to services in order to:

- *Discover the challenges to people with issues around substance use, mental health or homelessness, or all three in light of COVID-19*
- *Examine the factors associated with these issues in terms of services, especially at the time of lockdown and following partial re-opening of services*
- *Understand the impact these changes have made in terms of the mental health of the service users*

By participating in this research, you will be helping us to get a clearer picture of the problems the participants might face and what they feel may be needed going forward.
In particular, we want to know how the response to COVID-19 has affected them in terms of their psychological health and well-being.

Who will we be talking to?

We are asking a number of individuals with mental health, substance use and/or homelessness experiences to talk to us in the form of an audio recorded interview.

What do you need me to do?

We would greatly appreciate your assistance with this research by agreeing to act as a contact point/gatekeeper for some of your service users. We would hope to speak to 12 people in total.

The criteria for inclusion are as follows:

- Be over the age of 18 years
- Have experienced homelessness or housing instability, mental health or substance use issues of a combination of any of these before and during COVID-19 restrictions
- Be in receipt of services from MQI and/or HSE Mental Health Team
- Have the capacity to give explicit and informed consent

How will the interviews be conducted?

The interviews will take on average 40 minutes and will be conducted at a place and time chosen by the participant. This may mean that you will have to provide a space for the interview at your location or at a pre-arranged place (such as a coffee shop). It may also mean that you may have to sit in on the interview if this is what the participant wishes. Each participant will be given an Information Leaflet and a Consent Form beforehand to explain the research study and what they are agreeing to in terms of GDPR. If you feel you know someone who would like to participate, please let us know.

What happens next?

We can give you the information to pass on to them and given them some time to make a decision (usually a week). If they agree to participate, we will contact them (or set up an interview through you) and go through the consent form again with them.
We appreciate you taking the time to read this letter and look forward to working with you in the near future. Please do not hesitate to get in contact with me if you need any questions answered.

SERVICE USER PARTICIPATION INFORMATION LEAFLET

An exploration of the impact of COVID-19 on the mental health of service users.

What is this study about?

This is a study about people who are accessing services, who may have had their services affected by COVID-19 and how this is affecting their mental health and well-being.

Why have I been asked to take part?

As a person who has been accessing these services, we are asking you to tell us about your experiences around the changes that COVID-19 is having/has had on your services as well as on your mental health.

Specifically, the research aims to document and analyse the experiences of individuals linked in to services in order to:

- *Discover the challenges to people with issues around substance use, mental health or homelessness, or all three in light of COVID-19*
- *Examine the factors associated with these issues in terms of services, especially at the time of lockdown and following partial re-opening of services*

- *Understand the impact these changes have made in terms of the mental health of the service users*

By participating in this research, you will be helping us to get a clearer picture of the problems you might face and what you feel may be needed going forward.
In particular, we want to know how the response to COVID-19 has affected you in terms of your health and well-being.

Do I have to take part? Can I withdraw or change my mind?

We are asking for you to participate in this study, however participation is your decision entirely. You can decide to withdraw at any time.

How is the study being carried out?

If you do consent, this participation will take the form of an interview which will be audio-recorded. The information you give us will be private and your name will not be mentioned in any report.

What happens if I decide to take part?

Our researcher or your case worker will contact you to set up a time and place that suits you and will ask for your opinions in an interview. The interview will take about 40 minutes. Again, you can withdraw at any stage or refuse to answer questions if you wish.

Are there benefits to taking part?

We hope that by writing a report that takes the views of people who have experience of what happened during COVID-19, and how it has affected them will help inform the development of services going forward.

What information about me will be in this study?

While your opinions will be included as part of the study, you will not be identified in any way when the report is being written. We will take care to make sure that any identifying information is removed.

What happens to my personal data?

Personal data given to the researchers by you will be processed only as necessary and with as few people involved as possible. All data will be stored with Merchant's Quay Ireland by the Data Protection Officer for a period of 7 years, after which it will be destroyed. Your information will be held under a special code which ensures that you are not identified.
You have rights to see what we have written, to change or delete some of the information you have given us as well as the right to correct things if they are wrong.

Who is organising the study?

This study is being funded by the HSE and MQI.

Is there any payment for taking part?

There is no payment for taking part in this study. We will travel to you to conduct the interview so that travel does not affect your ability to participate.

What happens next?

If you feel you would like to participate, please let us know and we will contact you regarding a consent form and some more information about the research if you need it. If you decide that you do want to take part and then change your mind this is fine.

What is the lawful basis to use my personal data?

By law we can use your personal information for scientific research (in the public interest). We will ask for your explicit consent to use your data as a requirement of the Irish Health Research Regulations.

Thank you for taking the time to read this leaflet and considering your participation. Please do not hesitate to contact me if you have any further questions.

SERVICE USER CONSENT FORM

An exploration of the impact of COVID-19 on the mental health of service users.

As you know, we are currently conducting a study on how people have coped with changes in services during COVID-19 lockdown and afterwards. We are asking a number of people to tell us about their experiences around this issue.

In particular, we want to know what effects COVID-19 has had on you in terms of your mental health. We also want to know what you think can or should be done about this. We would particularly like to know of instances of particular difficulty for you.

We also want to know generally what you think should be done going forward to help with these issues.

We are asking for you to participate in this study, however participation is your decision entirely. If you do consent, this participation will take the form of a 40-minute interview which will be audio recorded. We will ask you some general questions about your background as well as questions about how you are currently coping on a day-to-day basis.

Your responses will be anonymous. You will not be named in any report. Your participation is voluntary. You can withdraw form participation at any time before, during or after your reflection is completed.

Privacy

Your responses will be anonymous. No information from which you could be directly or indirectly identified will be published. Data will be stored securely on a double encrypted computer and only the research team will have access to your transcripts. No names, contact or other personal details will be assigned to your responses. Data storage will meet the requirements of the Data Protection Acts 1988 - 2018 and the 2018 General Data Protection Regulation (GDPR). All data will be stored for a period of 7 years and then destroyed.

Your input will be included into an overall research study, which will be made publicly available, but again anonymously.

Consent to participate:
Please tick as appropriate:

I have read and understand the information leaflet for the above study. The information has been fully explained to me and I have been able to have any questions answered.	
I understand that this study is entirely voluntary, and if I decide I do not want to take part, I can stop at any time without giving a reason. I understand that deciding to withdraw or not participate will not affect my future support.	
I understand that I will not be paid for taking part in this study.	
I know how to contact the researcher if needed.	
I agree to participate having been fully informed of the risks and benefits set out in the information leaflet.	
I understand that my data will be protected, and that I will not be identified and that my information will only be shared in the form of a report.	
I understand that there are no direct benefits to me from participating in this study.	
I understand that I can stop at any time without giving a reason and refuse to answer any questions I do not like.	
I consent to audio-recording of the interview.	

Name: ______________________________

Date: ______________________________

Researcher Name and Date: ______________________________

APPENDIX 2

Interview Schedule

Hi, thanks for taking the time to talk to me. Maybe we could start off by telling me a little about yourself? (probe: education, employment, housing, marital status)

Is it ok to ask you now about the kind of services that you have been using with (MQI and/or HSE) before the Coronavirus lockdown started? (prompt: this is from March – St Patrick's Day) (probe: reason for service use, type of supports accessed, length of time accessing services)

And can you tell me about the kind of changes that the COVID-19 restrictions had on those services? (prompt: this is from March – St Patrick's Day) (probe: changes in: availability of services; prescribing; needle exchange; mental health support (counselling); housing).

Can you tell me how you are managing these changes? (probe: have they been difficult; if move to online, do they have internet access; do they miss face-to-face contact/group therapy).

And can you tell me about how easy or otherwise it has been to comply with regulations? (probe: social distancing; hand washing; mask wearing; shared spaces)

And what about contact with friends and family? (probe: less face time contact; loss of family routines/support)

Was there anything good about the lockdown and changes that have taken place since? (probe: in some instances, this may have been of benefit – i.e. improved housing situation/increased take-aways for MMT etc)

What do you think has been the most difficult thing about the virus for you? (probe: has it been fear of contracting the virus; social isolation; higher levels of anxiety/depression; lack of choice/control autonomy; paternalism/infantilism).

Is there anything that you feel would help make things better for you? (probe: changes in service delivery)
Is there anything else you would like to share with us that you think would help other people in the same situation as you?

Is there anything that I should have asked that I left out?

Do you have any questions for me?

Thank you very much for taking the time to participate. Talking about your experiences has been very valuable for the research project.